# MED - Long Term Care Intermediate Care Facility for Intellectual Disability - Admission Level of Care Certification Review

**Purpose:** To provide admission reviews for Intermediate Care Facility for Intellectual Disability (ICF/ID) admission level of care (LOC) determinations.

## Identification of Roles:

Review Coordinator (RC) – reviews documentation submitted by fax to determine the appropriateness of ICF/ID LOC at admission and maintains review documentation.

Manager - prepares monthly program activity reports, quarterly performance standard reports, and aggregate facility reports.

Medicaid Medical Director (MMD) – reviews member cases unable to be approved directly by RC and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Psychologist Peer Reviewer or Consultant Reviewer (PR) – external peer reviewing medical records to make a LOC decision.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases unable to be approved directly by RC and makes a determination based on the medical record and additional documentation provided.

Project Assistant (PA) - assists with coordinating information.

## Performance Standards:

- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.

## Path of Business Procedure:

**Step 1:** The review coordinator (RC) will accept and process requests for admission review from a qualified medical professional by fax. The ICF/ID LOC certification form (Form 470-4393) will be completed by a qualified medical professional that is not employed, under contract or otherwise associated with the facility and faxed to medical services. A qualified professional is a medical doctor (MD), doctor of osteopathy (DO), physician's assistant or certified nurse practitioner.

**Step 2:** The LOC reviews are to be completed for members upon admission or new eligibility for Medicaid, and any time there is a significant change in the member's health status that may affect their LOC.

a. It is the responsibility of the ICF/ID facility to notify Medical Services of any change in the member's condition.
b. Members readmitted to ICF/ID care from the hospital need to be reviewed with a new LOC certification form if the hospital stay was greater than 30 days.

c. Members being admitted to ICF/ID care after a hospital stay that lived in a community setting prior to hospital admission will be limited to an initial 30 day approval and need to resubmit information for a SSR review.

**Step 3:** The RC will data enter LOC request information into Medicaid Quality Utilization Improvement Data System (MQUIDS).

**Step 4:** RC will complete substantiation of admitting diagnosis using the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) criteria or criteria required for having a related condition. A psychological evaluation must be made on or before admission but no more than three months prior to admission. The RC will request the psychological evaluation for review.

**Step 5:** The DHS identified the Assessment and Services Evaluation (ASE) criteria as the standard to determine if the member meets the LOC based upon the information provided on the LOC certification form (Form 470-4393).

**Step 6:** The RC evaluates the following functional areas. Member must be able to benefit from treatment or programming in at least three or more of the following areas:

1. Mobility
2. Musculoskeletal skills
3. Activities of daily living
4. Domestic skills
5. Toileting
6. Eating skills
7. Vision, hearing and /or speech
8. Gross/fine motor skills
9. Sensory
10. Academic skills
11. Vocational skills
12. Social/community skills
13. Behavior
14. Health care

**Step 7:** Additional information will be obtained to facilitate assessment of the member's complete level of functioning, if needed. Non-clinical staff does not interpret clinical information or make clinical determinations.

**Step 8:** The RC will refer the case to a psychologist peer review (PR) for determination of primary ID/MR diagnosis or a related condition. The CAMD or MMD will be contacted for determination of medical necessity if the criteria are not met.

Only peer reviewers make denial decisions. Denial decisions are completed in writing by letter. Peer reviewers include licensed health care professions in the same category as the attending provider. Denials made by the Clinical Assistant to the Medicaid Medical Director (CAMD) will be reviewed by the Medicaid Medical Director (MMD). Notice of the availability of the peer-to-peer conversation is included in the letter. The manager will arrange for the peer-to-peer conversation within one business day of the request unless there are extenuating circumstances outside of Medical Services' control. Refer to MED Administrative Functions Peer-to-Peer Conversations for details on this procedure.

**Step 9:** The RC will enter criteria in the MQUIDS system on the ICF/ID review tab as supported by review information.

a. If not met, the review status will be entered as pending and the pending reason will be entered. RC will refer the case to a psychologist PR for determination of primary ID/MR diagnosis or a related condition. The CAMD or MMD will be contacted for

determination of medical necessity if the criteria are not met. If met, ICF/ID will be selected as the “disposition” to indicate the LOC approved.

**Step 10:** The RC will enter on the ICF/ID review tab of MQUIDS the number of approved days of care. Date of next review will auto-populate as 365 days and should be adjusted for shorter term approvals.

**Step 11:** Members under age 5 and over the age of 60 to qualify for ICF/ID LOC, the case must be referred to PR for approval.

# Level of Care Certification for Facility

**PLEASE PRINT OR TYPE**

**Fax form to:** Iowa Medicaid Enterprise Medical Services (515) 725-1349
Medical professional completing this form must provide a copy to the admitting facility.

| Today's Date / / | Iowa Medicaid Member Name | Social Security or State ID # | Birth Date / / |
|---|---|---|---|
| | | | |

## Medical Professional completing form (MD, DO, PA-C or ARNP required)

| Name | Telephone Number (10 digits) |
|---|---|
| | |
| Address, City, State, Zip | |
| | |
| Admit to: ☐ Nursing Facility ☐ Intermediate Care Facility for the Intellectually Disabled<br>Discussion occurred regarding alternatives to facility placement? ☐ Yes ☐ No<br>Date of discussion: / / | |
| Anticipated admission date: / / | Anticipated length of stay: days<br>Time limited stay? ☐ Yes ☐ No |

## Facility Information (NF or ICF/ID)

| Facility Name | |
|---|---|
| | |
| Address, City, State, Zip | |
| | |
| Telephone Number (10 digits) | Fax Number (10 digits) |
| | |

**ATTACH MEDICATION AND DIAGNOSES LISTS (WITH ICD CODES) SEPARATELY**

## Skilled Nursing Needs: Check all boxes that apply.

| | | |
|---|---|---|
| **Therapies** provided 5 days a week:<br>☐ Physical<br>☐ Occupational<br>☐ Speech<br>Duration expected: _____ | **Medications** provided daily:<br>☐ Intravenous<br>☐ Intramuscular<br>Drug name, dose, length of treatment:<br>_____ | **Stoma care** in early postop phase requiring daily care:<br>☐ Colostomy ☐ Ileoconduit<br>☐ Suprapubic catheter site<br>☐ Ileostomy ☐ Nephrostomy |
| **Respiratory therapy** daily:<br>☐ Nasotracheal suctioning<br>☐ Tracheostomy care<br>☐ Ventilator at least 8 hours/day | **Tube feeding**:<br>☐ More than 26% of calorie intake per day/minimum of 501 cc/day<br>Name/brand, dose, length of treatment:<br>_____ | **Wound care** for at least Stage 4<br>☐ Sterile dressing change daily<br>☐ Wound vac care |

## Functional Limitations: Check all boxes that apply.

| | | |
|---|---|---|
| **Cognition**<br>☐ No problem<br>☐ Language barrier<br>☐ Short/long term memory problem<br>☐ Problems with decision making<br>☐ Interferes with ability to do ADLs<br><br>BIMS score (if applicable) _____ | **Dressing**<br>☐ Independent<br>☐ Supervision or cueing needed<br>☐ Physical assistance needed<br>Frequency of needed assistance:<br>☐ 1-2 x weekly<br>☐ 3-4 x weekly<br>☐ >4 x weekly<br>☐ Age appropriate | **Medications**<br>☐ Independent<br>☐ Requires setup<br>☐ Administered by others<br>☐ Insulin, set dosage<br>☐ Insulin, sliding scale<br>☐ Frequent lab values |
| **Ambulation**<br>☐ Independent<br>☐ Cane<br>☐ Walker<br>☐ Wheelchair<br>☐ Motorized scooter<br>☐ Needs human assistance<br>☐ Transfer assist<br>☐ Restraint used | **Behaviors**<br>☐ None<br>☐ Requires 24-hour supervision<br>☐ Noncompliant<br>☐ Destructive or disruptive<br>☐ Repetitive movements<br>☐ Antisocial<br>☐ Aggressive or self-injurious<br>☐ Anxiety<br>☐ Depression | **Bathing/Grooming**<br>☐ Independent<br>☐ Independent with assistive devices<br>☐ Supervision or cueing needed<br>☐ Physical assistance needed<br>Frequency of needed assistance:<br>☐ 1-2 x weekly<br>☐ 3-4 x weekly<br>☐ >4 x weekly<br>☐ Age appropriate |
| **Skin**<br>☐ Intact<br>☐ Ulcer - Stage _____<br>☐ Open wound<br>☐ Daily treatment<br>☐ Treatment as needed | **Elimination**<br>☐ Continent<br>☐ Bladder incontinence<br>☐ Bowel incontinence<br>☐ Urinary catheter<br>☐ Chronic colostomy/ostomy<br>☐ Chronic nephrostomy<br>☐ Age appropriate<br>☐ Physical assistance needed | **Respiratory**<br>☐ No issue<br>☐ O2 use daily<br>☐ O2 as needed<br><br>**Eating**<br>☐ Independent<br>☐ Assistive devices<br>☐ Requires human assistance<br>☐ Age appropriate |

Additional comments:

Signature with title of medical professional completing certification form (MD, DO, PA-C, ARNP):

## Nursing Facilities Only

Did the member come to the NF from a recent acute hospital stay? ☐ Yes ☐ No

Member's living situation prior to acute hospitalization:
☐ Own residence ☐ Family/relative home
☐ Other (describe):

Will member be applying for HCBS waiver services? ☐ Yes ☐ No

## ICF/ID Facilities Only: To be completed by admitting facility or case manager.

| | |
|---|---|
| Name of Facility Contact Person | Telephone Number (10 digits) |
| D&E (preadmission evaluation) date:<br>/ / | Date psychological evaluation completed *(must be completed before admission but no more than 3 months prior to admission):* / / |
| ID diagnosis (mild, moderate, severe) or related condition: | FSIQ Score: _____ |
| Full Name of Diagnosing Psychologist | |
| Check areas in which the member would benefit from ICF/ID programming/treatment:<br>☐ Ambulation and mobility<br>☐ Musculoskeletal disabilities/paralysis<br>☐ Activities of daily living (ADLs)<br>☐ Elimination<br>☐ Eating skills | ☐ Sensorimotor<br>☐ Intellectual/vocational/social<br>☐ Maladaptive behaviors<br>☐ Health care<br>☐ Alternative level of care assessment |
| Signature with title of person completing ICF/ID information: | |

## Instructions for Level of Care for Facility

Purpose — Form 470-4393, *Level of Care Certification for Facility*, provides a mechanism for a medical professional (MD/DO/ARNP/PA-C) to report level of care needs for a Medicaid member's admission or change in condition for level of care.

Source — This form is available on the DHS website under Provider Forms.

Completion — A provider (MD/DO/ARNP/PA-C) must complete the form when a:

- Medicaid member is going to be admitted to a NF or ICF/ID.
- Medicaid member residing in a NF or ICF/ID has a significant change in condition.

Distribution — Providers fax the certification for level of care form to the IME Medical Services Unit (515-725-1349) and provides a copy to the admitting facility.

***The form may be faxed by the medical professional completing the form or by others involved in arranging the services (facility staff, hospital discharge planner, case manager or family member). The IME Medical Services Unit will make a level of care determination upon receipt of the form.***

Data — **Today's Date:** The date the form is completed (MM/DD/YYYY).

**Iowa Medicaid Member Name:** The Medicaid member's first name, middle initial, and last name as it appears on the eligibility card.

**Social Security or State ID #:** The member's social security number or state identification number as it appears on the eligibility card.

**Birth Date:** The Medicaid member's birth date (MM/DD/YYYY) as it appears on the eligibility card.

**Medical Professional Section**

**Name, Telephone Number with Area Code, and Address:** Specific information about the medical professional filling out the form.

**Admit to:** The type of facility, attestation of, and date of discussion about alternatives to facility placement.

**Anticipated admission date:** The expected or actual date of admission to the facility (MM/DD/YYYY) and anticipated stay.

**Facility Information**

**Facility Name, Address, Telephone and Fax Numbers with Area Code:** The facility specific information related to the level of care certification.

**ATTACH MEDICATION AND DIAGNOSES LISTS (WITH ICD CODES) SEPARATELY:** Provide current medication and diagnoses lists as separate attachments.

**Skilled Nursing Needs:** Check all boxes that apply to the member regarding skilled nursing needs for therapy, medications, wound care, stoma care, ventilator, tracheostomy care or tube feedings. Also complete functional limitations section below.

**Functional Limitations:** Check all boxes that apply to the member's functional abilities.

**Additional comments:** Additional pertinent comments from the medical professional.

**Signature with title of medical professional (MD/DO/PA/ARNP)** completing the form.

**Nursing Facilities Only:** Previous hospital placement, previous living situation, and plan for waiver application.

**ICF/ID Facilities Only:** Facility contact name and telephone number, preadmission evaluation date, ID diagnosis with FSIQ score, full name of diagnosing psychologist. Check all areas in which the member would benefit from ICF/ID admission or subsequent service.

**Signature** of person completing ICF/ID information.

# MED - Long Term Care Intermediate Care Facility for Intellectually Disabled - Admission Approval and Denial Decisions

**Purpose**: To approve or deny LOC based on established criteria. Subsequent service review processes are described in the onsite review procedure.

## Identification of Roles:

Review Coordinator (RC) – reviews information presented on Form 470-4393, documents case information, and criteria. If the criteria are met RC approves the level of care. If the criteria are not met the RC prepares information for peer review and completes denial letter.

Project Assistant (PA) – disseminates denial letters.

Manager – provides additional review regarding denials.

Physician Review – makes level of care determination.

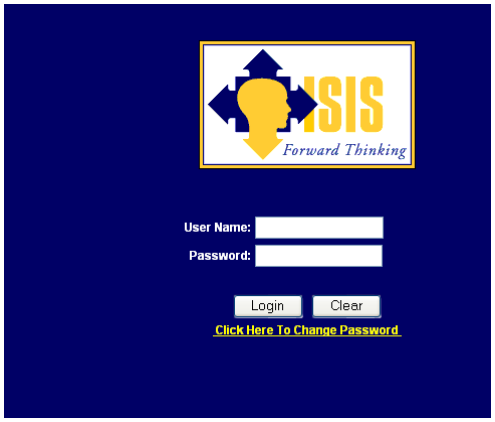
Psychologist Peer Reviewer or Consultant Reviewer (PR) – external peer reviewing medical records to make a LOC decision.

## Performance Standards:

- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.

## Path of Business Procedure:

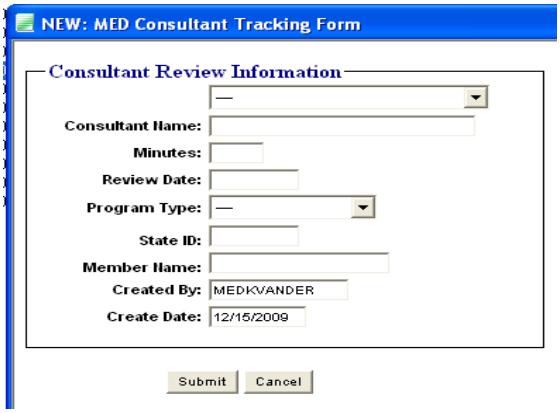
**Step 1:** When there is enough information to support approval of ICF/MR LOC the RC will approve the request.
**Step 2:** Approval decisions are provided to the facility via the Individualized Services Information System (ISIS) via the internet.
**Step 3:** The RC will log onto ISIS via Internet explorer https://secure.dw.dhs.state.ia.us/isis with user name and password.



**Step 4:** If the RC is unable to approve ICF/ID LOC, in the member's case in ISIS the RC will select PR when answering ISIS milestone on the status page for the member.
**Step 5**: The RC will prepare the case to send to a psychologist PR to review for determination of primary ID/MR diagnosis or a related condition. The CAMD or MMD will be contacted for determination of medical necessity if the criteria are not met. The RC will send all necessary documents for LOC determination to the respective PR for a LOC determination.
**Step 6:** Once the PR form with a decision is received, the PA will enter the following data in OnBase:

a. Consultant Name
b. Member's Name
c. Member's state identification (SID) number
d. Date of review
e. Time spent in minutes by the PR for the review

**Step 7:** The PA will log PR information into OnBase in the Consultant Tracking form.




**Step 8:** If the review is sent to a psychologist for review, the PA will send the PR determination to the RC's Back from Phys/Con Review queue in OnBase.
**Step 9:** The RC approves the case in ISIS.

a. If the PR results in denial determination, the RC will document the denial in WPM and ISIS.

**Step 10:** All denials documented in ISIS require a reason and rationale of why the member was denied in the comments section for the milestone.
**Step 11:** The RC adds the member's name to the facility denial spread sheet located here: O:\Denials\Facility Denials\Facility Denial Spread Sheets.
**Step 12:** Denial notices of decision and appeal rights are provided to the member and the ICF/ID facility by Medical Services.
**Step 13:** Admission denials are effective from the date of admission.
**Step 14:** The RC will document the denial in the Onsite ICF_MR O:\Denials\Facility Denials\Facility Denial Spread Sheets

a. If during the PR process the RC receives additional information, which would allow the RC to approve the case; the RC will approve and enter in ISIS and MQUIDS.
b. If additional information is received after the denial has been issued then the case is a reinstatement.

**Step 15:** Denial and modification decisions are made in writing by the NOD and sent to the member, the attending physician, the case manager, and the facility.

a. The written notice must include the principle reason and the clinical rationale for the decision. Appeal rights are included in the notice.

**Step 16:** A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the notice of decision letter by contacting the local DHS office, by writing a letter to DHS Appeals Section or by filing on line at http://www.dhs.state.ia.us/dhs/appeals/appeal_decision.html. The notice of decision letter contains instruction on how to request an appeal. Medical Services provides testimony for assigned appeal hearings.

a. Refer to appeals section from the Policy Support\Operational and Procedure. The Policy Support operational procedure is located at IME universal/operational procedures/medical services/Policy Support.doc

**Step 17:** The PA will record this information in MQUIDS.

a. This includes the name of the judge, the date of the decision and the outcome of the appeal with any notes pertinent to the case.

## Forms/Reports:

Denial Spreadsheet

| SID # | Member Name (Last Name, First Name) | Date of Denial | Denial Letter Mailed | Review Coord | Comments | Reinstated | Validated (For Internal Use) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

## Peer Reviewer Rationale Form

DCN:
Member Name:
State ID#:
Program:
Admission or annual:

Peer Reviewer name:
Peer Reviewer Decision (check one):

ICF/ID: ☐YES ☐NO
MR Diagnosis: ☐YES ☐NO

Please provide specific rationale for your decision: _____

_____

_____

_____

_____

_____

_____

Please indicate amount of time spent reviewing this case:

_____

If you have any questions, contact [Review Coor] at [office number] or 1-800-383-1173. Fax completed PR form to 515-725-1349.

SIGNATURE _____ DATE _____
ICF/ID

Notice of Decision Letter

DATE

MEMBER NAME
FACILITY
ADDRESS

Dear MEMBER NAME:

The Iowa Department of Human Services provides a level of care review for Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). After reviewing the medical record information supplied by facility staff Medical Services determined that we are unable to approve the admission for you based on the information submitted for the following reason:

> You do not have an Intellectual Disability diagnosis or a condition related to Intellectual Disability. Therefore, you may not be certified for ICF/ID level of care.

This action has been taken pursuant to 42 CFR 440.150, Iowa Code Section 135C.1(9) and Iowa Administrative Codes 441-82.7(3) and 22.1. The facility was notified of this decision on October 4, 2010. The attending physician/psychologist may request a peer-to-peer conversation with the peer reviewer who made the decision by calling 800-383-1173 or locally 256-4623.

If you disagree with this decision, you have the right to appeal. See the back of this letter to find out how to file an appeal.

Sincerely,

Iowa Medicaid Enterprise, Medical Services

cc: Attending Physician:
Income Maintenance Worker:
Administrator:

Nod.d.ltr.A3.5.05

## RFP Reference:
6.2.6.2

## Interfaces:
ISIS
MQUIDS
OnBase

## Attachments:
N/A

## MED - Long Term Care Intermediate Care Facility for Intellectually Disabled Level of Care Certification Review - Reports

**Purpose:** To provide details regarding compliance with performance standards and program activities related to the LOC review process for ICF/MR facilities.

## Identification of Roles:

Project Assistant (PA) - assists manager in database management, providing query data, developing report formats, assist with monthly, quarterly, and annual reports.

Review Coordinator (RC) – completes inspection and compile results of member and facility review.

Manager - prepares monthly program activity reports, quarterly performance standard reports, and aggregate facility reports.

## Performance Standards:

Provide the required reports within ten business days of the end of the reporting period (quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in June.

## Path of Business Procedure:

**Step 1:** The manager will access ISIS management reports and clinical data documented in MQUIDS to report the following to DHS policy staff quarterly:

a. Number of admissions completed by program
b. Number of continued stay reviews completed by program
c. Percent of reviews completed timely
d. Number of denials per program

**Step 2:** Manager compiles quarterly report and other ad hoc reports as requested.

## Forms/Reports:

Quarterly and annual reports as directed by DHS.

## RFP Reference:

6.1.3.4.1
6.1.3.4.3

## Interfaces:

N/A

## Attachments:

N/A

## MED - Long Term Care Intermediate Care Facility for Intellectually Disabled Level of Care Certification Disruption of Business Plan

**Purpose:** To provide business procedures in the event of disruption in electronic capabilities

## Identification of Roles:

Review Coordinator (RC) –reviews information presented by LOC requests and documents case information and criteria in word format

Project Assistant (PA) – receives LOC request, enters on spreadsheet, routes to the appropriate RC and sends notices to providers as needed. All activities will be noted on the manual tracking log.

Manager – provides management support regarding business disruption procedures

## Performance Standards:

- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.

## Path of Business Procedure:

In the event that the procedures outlined above are disrupted due to power outages that impact normal systems operations for longer than two hours the following paper procedures will apply.

**Step 1:** The RC will receive review request by telephone and will log calls capturing the following information:

1. Date received
2. Member name
3. Member State ID
4. Caller name

**Step 2:** The RC will document review information following the ICF/ID certification form 470-4393.
**Step 3:** The RC will enter review information in MQUIDS when systems are restored.
**Step 4:** The RC will document compliance with criteria by paper copies of criteria.

## MED - Long Term Care 456 Inspection of Care for Intermediate Care Facilities for Intellectually Disabled Facilities Medical Records Review and Subsequent Service Reviews

**Purpose:** Inspection of care for ICF/ID facilities will be performed to monitor quality, medical necessity and appropriateness of service and to provide subsequent service reviews for ICF/ID LOC determination.

## Identification of Roles:

Project Assistant (PA) – supports review activities, manages Inspection of Care Access database, and assists in coordinating team communications and schedules.

Review Coordinator (RC) – reviews medical record and assesses for quality, medical necessity and appropriateness of service. Refers level of care or quality of care concerns to peer reviewer.

Manager - provides education and consultation to RC regarding inspection findings.

Medicaid Medical Director (MMD) – reviews levels of care or quality of care concerns, makes medical necessity determinations and approves corrective action plan requests that include quality of care concerns.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews levels of care or quality of care concerns, makes medical necessity determinations and approves corrective action plan requests that include quality of care concerns.

Peer Reviewer (PR) – provides specialty review in LOC determination.

## Performance Standards:

- Complete 95% of LOC determinations for subsequent stays within five business days of receipt of complete information. Complete 100 percent within ten business days of receipt of complete information.
- Conduct annual onsite UR visits between months 10 and 12 following the prior year visit.

## Path of Business Procedure:

**Step 1:** The RC will review the current medical records for all members admitted at the time of the onsite inspection using the Inspection of Care tool for facility type.
**Step 2:** The RC will complete data entry using the access database.
**Step 3:** The RC will complete subsequent service reviews on all members admitted at the time of the onsite inspection to assure that continued care of the member is medically appropriate and that quality care is being provided.

- Subsequent service reviews are reviewed and entered into MQUIDS at the time of the LOC decision.

**Step 4:** RC will complete substantiation of admitting diagnosis using the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) criteria or criteria required for having a related condition.
**Step 5:** The DHS identified the Assessment and Services Evaluation (ASE) criteria as the standard to determine if the member meets the LOC.

**Step 6:** The RC evaluates the following functional areas. Member must be able to benefit from treatment or programming in at least three or more of the following areas:

1. Mobility
2. Musculoskeletal skills
3. Activities of daily living
4. Domestic skills
5. Toileting
6. Eating skills
7. Vision, hearing and /or speech
8. Gross/fine motor skills
9. Sensory
10. Academic skills
11. Vocational skills
12. Social/community skills
13. Behavior
14. Health care

**Step 7:** Additional information will be obtained to facilitate assessment of the member's complete level of functioning. Non-clinical staff does not interpret clinical information or make clinical determinations.

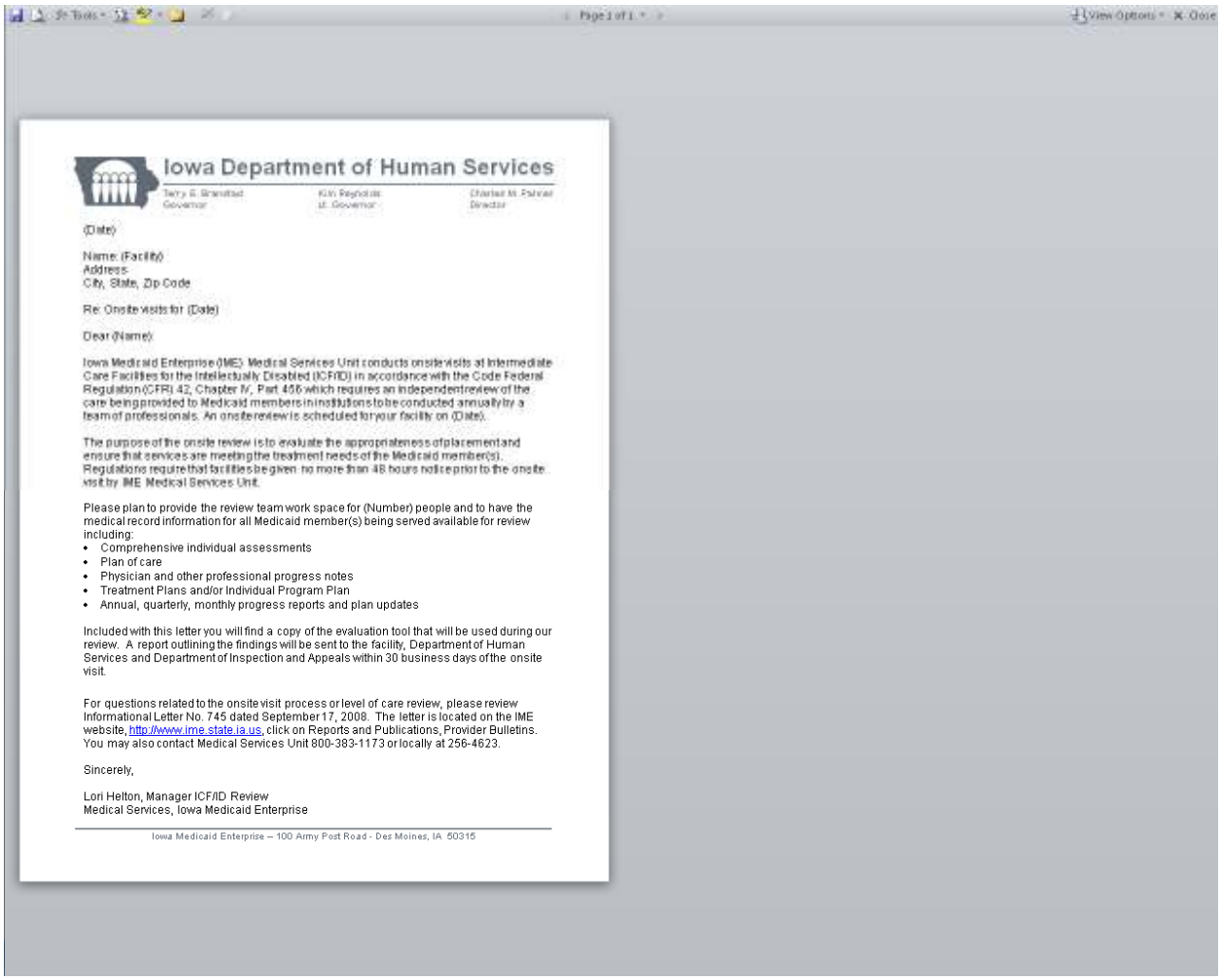
**Step 8:** The RC will refer the case to a psychologist peer review (PR) for determination if the criteria for a mental retardation diagnosis are not met and the CAMD if LOC criteria are not met.

Only peer reviewers make denial decisions. Denial decisions are completed in writing by letter. Peer reviewers include licensed health care professions in the same category as the attending provider. Denials made by the Clinical Assistant to the Medicaid Medical Director (CAMD) will be reviewed by the Medicaid Medical Director (MMD). Notice of the availability of the peer-to-peer conversation is included in the letter. The manager will arrange for the peer-to-peer conversation within one business day of the request unless there are extenuating circumstances outside of Medical Services' control.

**Step 9:** The RC will enter criteria in the MQUIDS system on the ICF/ID review tab as supported by review information, as well as current medications and diagnoses. If not met, the review status will be entered as pending and the pending reason will be entered. If met, ICF/ID will be selected as the "disposition" to indicate the LOC approved.

**Step 10:** The RC will enter on the ICF/ID review tab of MQUIDS the number of approved days of care which will be 365 days if change in the member's condition is not anticipated within the year. Date of next review will auto-populate.

## Forms/Reports:



Iowa Department of Human Services

Terry E. Branstad, Governor | Kim Reynolds, Lt. Governor | Charles M. Palmer, Director

(Date)

Name: (Facility)
Address
City, State, Zip Code

Re: Onsite visits for (Date)

Dear (Name):

Iowa Medicaid Enterprise (IME) Medical Services Unit conducts onsite visits at Intermediate Care Facilities for the Intellectually Disabled (ICF/ID) in accordance with the Code Federal Regulation (CFR) 42, Chapter IV, Part 456 which requires an independent review of the care being provided to Medicaid members in institutions to be conducted annually by a team of professionals. An onsite review is scheduled for your facility on (Date).

The purpose of the onsite review is to evaluate the appropriateness of placement and ensure that services are meeting the treatment needs of the Medicaid member(s). Regulations require that facilities be given no more than 48 hours notice prior to the onsite visit by IME Medical Services Unit.

Please plan to provide the review team work space for (Number) people and to have the medical record information for all Medicaid member(s) being served available for review including:

- Comprehensive individual assessments
- Plan of care
- Physician and other professional progress notes
- Treatment Plans and/or Individual Program Plan
- Annual, quarterly, monthly progress reports and plan updates

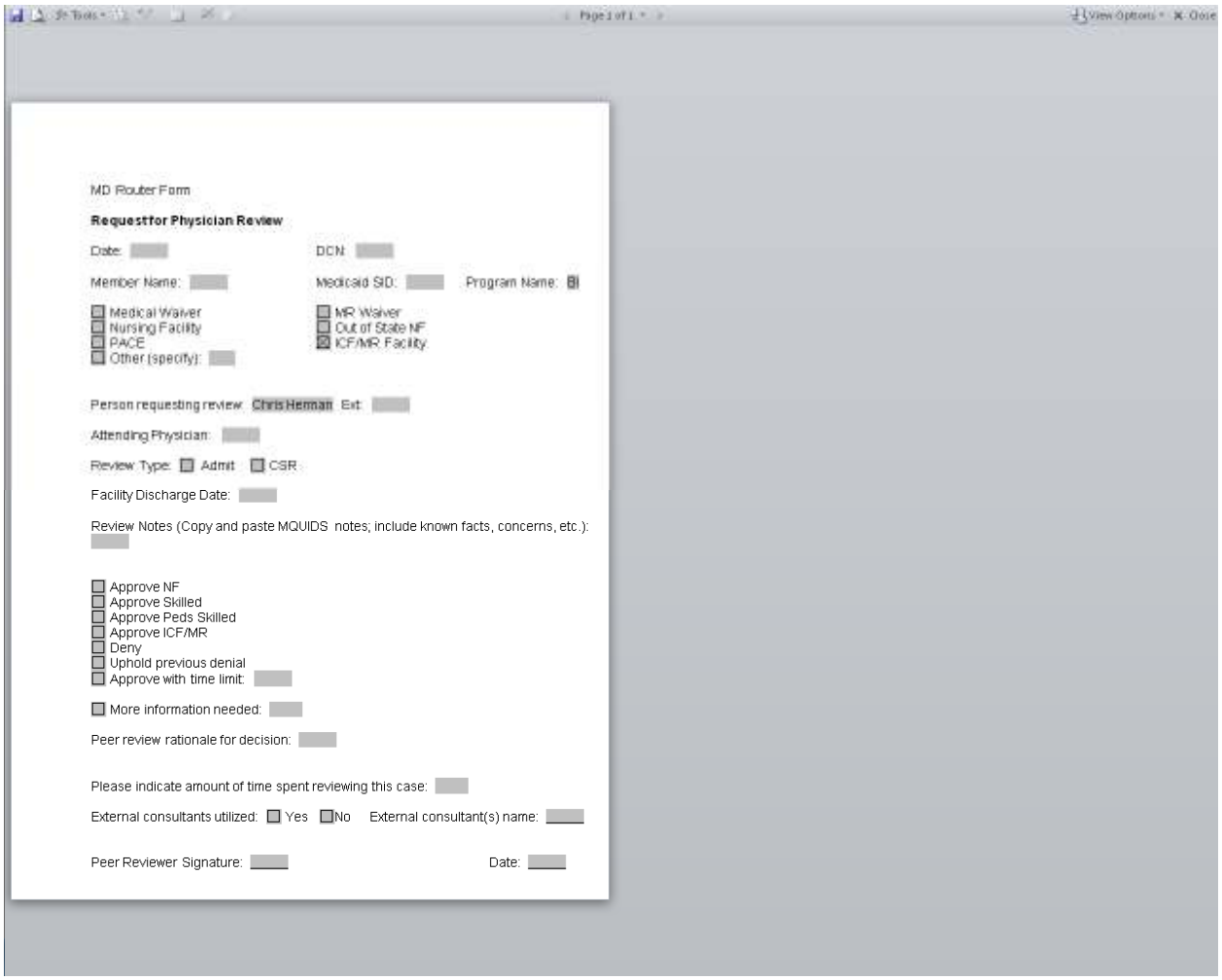
Included with this letter you will find a copy of the evaluation tool that will be used during our review. A report outlining the findings will be sent to the facility, Department of Human Services and Department of Inspection and Appeals within 30 business days of the onsite visit.

For questions related to the onsite visit process or level of care review, please review Informational Letter No. 745 dated September 17, 2008. The letter is located on the IME website, http://www.ime.state.ia.us, click on Reports and Publications, Provider Bulletins. You may also contact Medical Services Unit 800-383-1173 or locally at 256-4623.

Sincerely,

Lori Helton, Manager ICF/ID Review
Medical Services, Iowa Medicaid Enterprise

Iowa Medicaid Enterprise – 100 Army Post Road - Des Moines, IA 50315



MD Router Form

**Requestfor Physician Review**

Date: DCN:

Member Name: Medicaid SID: Program Name:

- ☐ Medical Waiver
- ☐ Nursing Facility
- ☐ PACE
- ☐ Other (specify):
- ☐ MR Waiver
- ☐ Out of State NF
- ☑ ICF/MR Facility

Person requesting review: Chris Herman Ext:

Attending Physician:

Review Type: ☐ Admit ☐ CSR

Facility Discharge Date:

Review Notes (Copy and paste MQUIDS notes; include known facts, concerns, etc.):

- ☐ Approve NF
- ☐ Approve Skilled
- ☐ Approve Peds Skilled
- ☐ Approve ICF/MR
- ☐ Deny
- ☐ Uphold previous denial
- ☐ Approve with time limit:

☐ More information needed:

Peer review rationale for decision:

Please indicate amount of time spent reviewing this case:

External consultants utilized: ☐ Yes ☐ No External consultant(s) name:

Peer Reviewer Signature: Date:

## RFP Reference:
6.2.6.2

## Interfaces:
MQUIDS
Access database

## Attachments:
N/A

## MED - Long Term Care 456 Intermediate Care Facilities for Intellectually Disabled Onsite Review Observation of Member

**Purpose:** Inspection of Care for ICF/ID facilities will be performed to monitor quality, medical necessity and appropriateness of service. Observation of the member is performed to ensure the member's health and safety needs are met and that the member is engaged in active treatment.

## Identification of Roles:
Review Coordinator (RC) – observes member at the facility during the Inspection of Care.

## Performance Standards:
Performance standards are not specified for this procedure.

## Path of Business Procedure:
**Step 1:** The RC will conduct observation of all members residing in ICF/ID facilities.
**Step 2:** The RC will complete the face-to-face observation of the member in the following situations:

a. Work or day treatment environment
b. Meal time
c. Planned leisure activity
d. Structured training time

This process does not have to involve a structured interview of the member and observation will be sensitive and respectful of the member.
**Step 3:** The face-to face observation time, location and date will be documented on the Inspection of Care Review Tool in Section D and in overall comments, if necessary.

## Forms/Reports:
N/A

## RFP Reference:
6.2.6.2

## Interfaces:
Access database

## Attachments:
N/A

## MED - Long Term Care 456 Intermediate Care Facilities for Intellectually Disabled Onsite Review Corrective Action Plan

**Purpose:** Facilities that do not meet standards for treatment planning, active treatment, treatment plan implementation, or who are not meeting the social, health and safety needs of the member will be required to submit a Corrective Action Plan (CAP) as directed by DHS.

## Identification of Roles:

Review Coordinator (RC) – completes onsite facility review and makes recommendation for CAP if necessary.

Project Assistant (PA) - compiles information given by the RC and sends to facility for review.

Manager – approves CAP recommendation and reports all quality concerns to MMD and DHS.

Medicaid Medical Director (MMD) – reviews and approves action plan recommendations involving quality of care concerns.

Clinical Assistant to the Medicaid Medical Director (CAMD) - supports medical director in quality of care reviews and review of action plans.

## Performance Standards:

Performance standards are not specified for this procedure.

## Path of Business Procedure:

**Step 1:** The RC will complete onsite inspection of care using the Inspection of Care tool and observation.

a. If urgent quality of care concerns are noted the RC will contact the manager immediately and describe the concerns.
b. Issues that may constitute quality of care concern include:
    1. Health and safety of member at risk
    2. Plan of care is incomplete, fails to address needs and/or not updated monthly
    3. Medications not reviewed at least every 90 days
    4. Progress notes not present
    5. Member is not benefiting from active treatment
    6. Member has service need identified, however, the facility is not providing the service to address the need or securing the service from arrangements with others
    7. Member is unable to tolerate active treatment due to medical reasons
    8. Facility is not providing active treatment
    9. Facility is not meeting the health needs of the member.
    10. Facility is not meeting the social needs of the member.

**Step 2:** Once the manager, DHS, or MMD, have made the determination for a corrective action, the facility is informed on the Inspection of Care tool sent within 30 days of the review and any corrective action that needs to be taken.

a. If an immediate threat to the member's health and safety is present, the manager will take action as directed by DHS

**Step 3:** Once the facility review is complete, a CAP is determined, and with manager approval, an aggregate letter will be created by the RA. The aggregate letter will give the total score of all of the members that were reviewed in that facility.

**Step 4:** The aggregate letter is mailed out within 30 days of the onsite review to the facility with copies of each member's Inspection of Care tool.

**Step 5:** It is expected that the facilities will have no more than 30 days from the date of the aggregated letter to address and correct the concerns by responding in writing detailing steps they are taking to address them.

a. The corrective action response will include the following information:
    1. Date of the onsite visit
    2. Name of member
    3. Member's SID
    4. Item(s) cited in the report to be corrected by Inspection of Tool number
    5. Explicit steps the facility has taken to correct the problem
    6. The planned steps undertaken to sustain change
    7. Date by which correction will be completed
    8. Staff responsible for the action plan

**Step 6:** Once the CAP is received from the facility, the manager will review and approve.

a. If there are concerns then the manager will review CAP with DHS and MMD.

**Step 7:** If a returned CAP is unacceptable, the facility will be notified in writing of necessary steps to correct.

**Step 8:** If further action to achieve compliance with a CAP is needed medical services will request direction from the DHS policy staff.

# Forms/Reports:

## Facility Aggregate

«FacName» «FacID»
Facility Director
«FacAddr1»
«FacAddr2»
«City», «ST» «ZIP»

RE: Onsite Visit - «FirstOfDateOnsite» - «LastOfDateOnsite»

Dear Facility Director:

Iowa Medicaid Enterprise (IME) Medical Services staff conducted an onsite visit at your facility on the date(s) identified above. This onsite review was conducted in accordance with the Code of Federal Regulation (CFR) 42, Chapter IV, Part 456, which requires an independent review of the care being provided to Medicaid members in institutions be conducted annually by a team of professionals.

Information regarding the Medicaid member's individual reviews that were completed during this timeframe are enclosed. The aggregated results of all reviews are as follows:

Number of members reviewed: «CountOfFacID»

| | | |
|---|---|---|
| Part A-Admission certification, plan of care: | Subtotal Score:«SumOfAST» | Possible Score: «SumOfATP» |
| Part B-Medical, psychiatric, and social evaluations: | Subtotal Score:«SumOfBST» | Possible Score: «SumOfBTP» |
| Part C-Appropriateness of treatment for level of care: | Subtotal Score:«SumOfCST» | Possible Score: «SumOfCTP» |
| Part D-Observation: | Subtotal Score:«SumOfDST» | Possible Score: «SumOfDTP» |
| Overall Score: | Overall Score:«SumOfTotalScore» | Possible Score: «SumOfOTP» |

Please review the enclosed individual member's review information for any corrective actions that are necessary for your facility. If corrective action is indicated, a formal corrective action plan must be submitted within 30 days of the date of this letter to Iowa Medicaid Enterprise, Medical Services, Attention: NAME, PO Box 36478, Des Moines, Iowa 50315.

Thank you for your assistance and the support received from your staff in completing this onsite review. For questions related to the onsite visit process or level of care review, please refer to Informational Letter No. 745 dated September 17, 2008. This letter can be found at the IME website, http://www.ime.state.ia.us, click on Reports and Publications, Provider Bulletins. You may also contact Medical Services Unit at
1-800-383-1173, extension XXXX, or locally at (515) 974-XXXX

Sincerely,

^, Manager, ICF/ID Review
Iowa Medicaid Enterprise, Medical Services

cc: Iowa Department of Human Services
Iowa Department of Inspections and Appeals

## MED - Long Term Care 456 Intermediate Care Facilities for Intellectually Disabled - Reports

**Purpose:** The reports will detail compliance with utilization review standards of 42 CFR 456 and include all results of performance standards and program activities.

## Identification of Roles:

Project Assistant (PA) - assists manager in database management, provides query data, develops report formats, and assists with monthly, quarterly, and annual reports.

Review Coordinator (RC) – completes inspection and compile results of member and facility review.

Manager - prepares monthly program activity reports, quarterly performance standard reports, and aggregate facility reports.

## Performance Standards:

- Provide the required reports within ten business days of the end of the reporting period (quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in June.

## Path of Business Procedure:

**Step 1:** The RC completes the Inspection of Care tool as required by the program and tallying scores of each section in the access database.
**Step 2:** The manager develops the report formats for the activity, quarterly narrative report and establishes the scoring algorithm for the scorecard.
**Step 3:** The PA completes queries as required to complete the reports.
**Step 4:** The manager finalizes compilation of data.
**Step 5:** The manager forwards the reports to the project assistant.
**Step 6:** The PA posts the reports on the IME universal share drive.
**Step 7:** The results of the annual evaluation will be documented in a report to the facility and to DHS within 30 days of the evaluation.

a. If documentation supporting the facility's program is not satisfactory, recommendations and request for corrective action will be submitted with the report to the facility and to DHS.

## Forms/Reports:

| Report Name | Frequency | Due Date | Measure |
|---|---|---|---|
| Member Inspection of Care Report | Annual | 30 Days after onsite review | Inspection of Care Tool Scores |
| Facility of Inspection of Care Report | Annual | 30 Days after onsite review | Aggregated scores of Inspection of Care Tool |
| | | | 1.) |
| Quarterly Narrative Report | Quarterly | 10th Working day following end of quarter | 1.) Number of inspections completed by facility type<br>2.) Number of corrective action plans required<br>3.) Type of concerns leading to requested correction action<br>4.) 10-12 Month timeliness information |

## RFP Reference:
6.1.3.4.1
6.1.3.4.3

## Interfaces:
N/A

## Attachments:
N/A

## MED - Long Term Care 456 Intermediate Care Facilities for Intellectually Disabled - Disruption of Business Plan

**Purpose:** In the event that the onsite inspection of care review operation is disrupted then the following procedures will be followed.

## Identification of Roles:
Review Coordinator (RC) –reviews information presented by LOC requests and documents case information and criteria in word format

Project Assistant (PA) – receives LOC request, enters on spreadsheet, routes to the appropriate RC and sends notices to providers as needed. All activities will be noted on the manual tracking log.

Manager – provides management support regarding business disruption procedures

## Identification of Roles:

Review Coordinator (RC) – reviews medical record and assesses for quality, medical necessity and appropriateness of service. Refers level of care or quality of care concerns to peer reviewer.

## Performance Standards:

Performance standards are not specified for this procedure.

## Path of Business Procedure:

**Step 1:** When laptop is not available then the RC will use paper copies of the tool to complete the onsite review.
**Step 2:** The RC will enter review information in the access database when restored.

## RFP Reference:

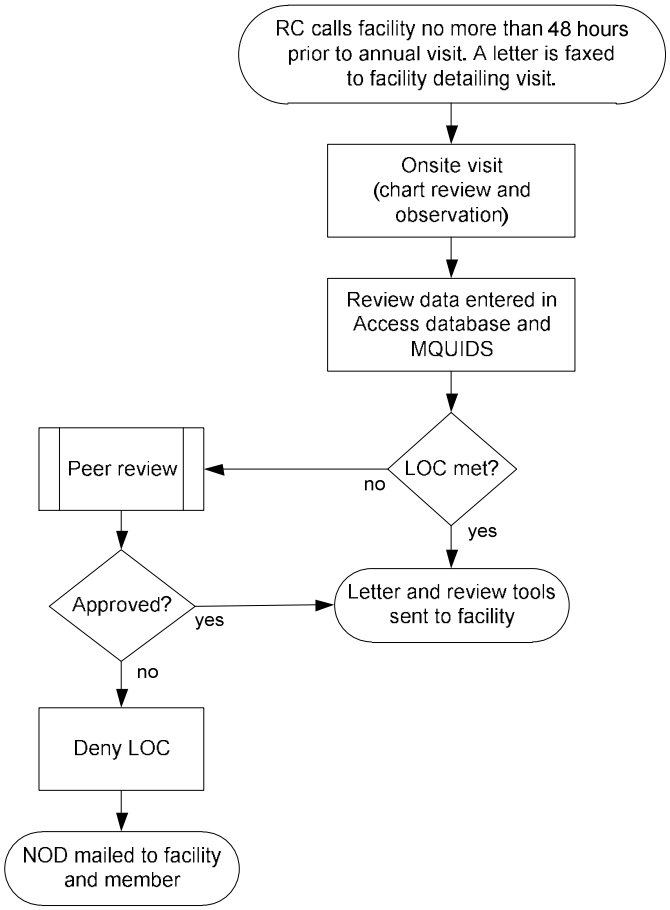
N/A

## Interfaces:

N/A

# Attachment A:

## ICF/ID Annual Facility Review

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